cirrhosis. At present, cirrhosis is not a counter – indication laparoscopic cholecystectomy if performed by experimental surgeons.

SUNDAY, FEBRUARY 23, 2014, 7:30AM–8:30AM PARALLEL COMPETITIVE VIDEOS A LIVER

CV-A.01 TOTALLY LAPAROSCOPIC RIGHT HEPATECTOMY BY CAUDATE HEPATOTOMY TECHNIQUE

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The patient is a 59 year-old woman with synchronous metastatic colon cancer to the liver. Cross-sectional imaging showed several hepatic tumors distributed in the right lobe. Given the location and distribution, a right hepatectomy was planned. This video describes our preferred anterior approach for a formal laparoscopic right hepatectomy– A generous caudate hepatotomy is used to help gain access to the main right portal vein. The coronary ligament is incised and the hepatic veins are exposed. The hilar dissection was commenced by exposing the right hepatic artery lying posterior to the common hepatic duct. The main RHA is clipped and divided. The main portal vein was dissected until the bifurcation is clearly identified. A caudate hepatotomy was done in order to allow isolation and division of the main RPV by a single firing of a vascular stapler. The line of demarcation along the interlobar plane was marked using electrocautery and the parenchymal transection was started. The caudate hepatotomy was extended further posteriorly beyond the hilum and then the anterior liver was divided. As the liver was opened, the right bile duct was transected intrahepatically. Coursing branches of the middle and right hepatic veins were also managed intrahepatically using a vascular stapler. The parenchymal transection plane was aligned along the right lateral edge of the IVC until the dissection reached the base of the Right hepatic vein. The RHV was identified and divided and the right hemi-liver was mobilized from diaphragm. The specimen was extracted via a low transverse incision.

CV-A.03 LAPAROSCOPIC RIGHT POSTERIOR SEGMENT LIVER RESECTION

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The purpose of this video presentation is to highlight one case from our experience performing laparoscopic, right posterior segment liver resection. We illustrate the postioning of patient, port placement, and the use of laparoscopic intraoperative ultrasound to define tumor position and approach to resection. Through our right side mobilization, which includes right lateral port placement through the chest, we show how we can access the right posterior liver. The use of an ultrasonic generator, bipolar cautery, and stapler for transection of the liver parenchyma are demonstrated. Lastly, we present extraction from a transvaginal route when combined with a gynecologic laparoscopic operation.

CV-A.04 ROBOTIC-ASSISTED RIGHT HEPATECTOMY

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Background: Different technical and technological advances have significantly reduced the morbidity and mortality of hepatic resection in the past 20 years. It has been proved that the use of minimally invasive procedures in liver surgery improved the postoperative comfort of the patient as well as some perioperative complications, like blood loose. Among minimally invasive surgeries, laparoscopy has occupied a place of privilege. However, it still has important limitations that Robotic technique evolved to overcome.
Materials and Methods: We present a Robotic-assisted right hepatectomy in a patient affected by colorectal liver metastasis.
Results: It is showed the different steps of the procedure which includes the liver mobilization and hilar dissection, the liver transection and right supra-hepatic vein section.
Conclusion: This video shows the efficacy and feasibility of Robotic liver surgery providing a three dimensional imaging, a greater instrumental movement and tremor filtering of the surgeon, thus reducing the minimally invasive surgery related complexity.

CV-A.05 LAPAROSCOPIC LEFT HEPATECTOMY COMBINING CUSA AND HARMONIC SCALPEL DISSECTION

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The development and increasing availability of laparoscopic versions of the so-called ‘energy devices’ for vessel sealing and division has been a boon to laparoscopic surgeons worldwide. Liver resection in particular has been aided by the improved performance and evolving ergonomics of these devices. However, there remains great benefit to be derived from the use of the laparoscopic version of the Cavitron Ultrasonic Surgical Aspirator, or ‘CUSA’, for many years, the workhorse of open liver resection. Herein, we describe our technique of parenchymal division during major hepatectomy, for which we employ the combined benefits of the CUSA and the Harmonic Scalpel. During a formal left hepatectomy, we demonstrate the precise parenchymal dissection made possible by the laparoscopic CUSA. We also demonstrate how the use of the Harmonic Scalpel in tandem with the laparoscopic CUSA can facilitate efficient parenchymal transection by avoiding unnecessary clip application which can be slow and may affect the use of laparoscopic staplers. We propose that this technique of liver resection is safe, efficient and precise.